

# LOW BACK PAIN ACTION PLAN



Name: \_\_\_\_\_

Medical Provider's  
Name: \_\_\_\_\_

Case Manager's  
Name: \_\_\_\_\_

Medical Social Worker's  
Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

## THINGS TO DO EVERYDAY:

### Use good lifting techniques:

- ☐ Bend at my knees
- ☐ Hold objects close to my body
- ☐ Push (don't pull) objects
- ☐ Get help if the object is heavy or awkward

### Get a good night's sleep:

- ☐ Take a warm bath before bed
- ☐ Sleep on my side with a pillow between my knees
- ☐ Sleep on my back with a pillow under my knees

## MANAGE MY PAIN:

- ☐ Stay active, but let my pain level guide me
- ☐ Try relaxation techniques
- ☐ Spend time with supportive friends and family sharing my thoughts
- ☐ Keep a healthy weight
- ☐ Have a good posture
- ☐ Take breaks to stretch at work or on long car rides
- ☐ Do exercises directed by my provider to reduce pain

## GOALS:

Date:

My Weight:

My Goal:

## MY PLAN:

If I have a flare up of low back pain, I will:

- ☐ Use a heating pad or take a warm bath
- ☐ Stretch
- ☐ Take medicines for back pain as directed by my medical provider
- ☐ Call my medical provider if I am not feeling any better

I will call my medical provider immediately if:

- ☐ If I have pain, weakness or tingling in my legs or I cannot control my urine or stool

## NOTES:



# LOW BACK PAIN ACTION PLAN

## MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)

Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important      1   2   3   4   5   6   7   8   9   10      Totally important  
☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident      1   2   3   4   5   6   7   8   9   10      Totally confident  
☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):